

## 11438 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>			
c. LENGTH OF STAY IN 1b <b>57 yrs.</b>				d. STREET ADDRESS <b>Wash. Ave. Ext.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S HOSP</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>VIOLE S. BENNETT</b>				4. DATE OF DEATH <b>NOV 26 1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 9, 1905</b>		9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>JACOB ALLEN</b>			
14. MOTHER'S MAIDEN NAME <b>BELLE BENSON</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>HOSPITAL CHART</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153X</b> <b>INTESTINAL OBSTRUCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF SIGMOID COLON</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>10 days.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>NOV 22, 1956</b> , to <b>NOV 26, 1956</b> , that I last saw the deceased alive on <b>NOV 26, 1956</b> , and that death occurred at <b>9 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESTERTOWN, Md.</b> DATE SIGNED <b>11-26-56</b>							
ACTUAL SIGNATURE <b>A. T. KEEFE JR.</b> M.D.				PHYSICIAN'S NAME (Type) <b>A. T. KEEFE JR. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 28-56</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for handwritten information, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

NOV 30 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11493

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11450

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>17 YRS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8415 DIXON AVENUE</b>				d. STREET ADDRESS <b>8415 DIXON AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>MELVIN</b> Middle <b>ALDYNE</b> Last <b>BILLER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/99</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Shipley Motor Sales</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>HEPNER, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN E. BILLER</b>				14. MOTHER'S MAIDEN NAME <b>ROSE WILLIAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>228-07-0002</b>		17. INFORMANT Address <b>MRS. RUTH L. BILLER, 8415 Dixon Ave., Apt. #2 Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sudden</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>Nov. 5, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 8, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Reformed Church Cemetery, Timberville, Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b> ADDRESS <b>Silver Spring, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>11/8/56</b>		24b. REGISTRAR'S SIGNATURE <b>James Potter</b>	

MEDICAL CERTIFICATION

2-15-1/2

2

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 13 1956  
BUREAU V. S.

11451

## CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rock Hall</b>				c. LENGTH OF STAY IN 1b <b>Rural Rock Hall</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Earl Boulter</b>				4. DATE OF DEATH Month Day Year <b>November 8 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1898</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edwin Boulter</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-320061</b>		17. INFORMANT Address <b>Lorraine Kendall-Rock Hall, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of left lung</b> <b>168x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 year (H)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 1953</b> , to <b>Nov. 8, 1956</b> , that I last saw the deceased alive on <b>Nov. 3, 1956</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D.				ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b>			
PHYSICIAN'S NAME (Type) <b>WILLARD F. SMITH, MD</b>				DATE SIGNED <b>11/10/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>Nov. 11</b>		<b>Wesley Chapel</b>		<b>Rock Hall, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>				ADDRESS <b>Church Hill, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/11/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>S. Howard Bruggers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

BUREAU V. S.

NOV 16 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11429

## 11439 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		LENGTH OF STAY (In this place) <u>8 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Avenue</u>				STREET ADDRESS (If rural give location) <u>Maple Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph Brice</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 8 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 5 1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brice</u>				14. MOTHER'S MAIDEN NAME <u>Anne Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>218-05-8217</u>		17. INFORMANT & ADDRESS <u>Miss Harriett Welch, Chestertown</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
430.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY INSUFFICIENCY</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 25, 1956</u> , to <u>November 8, 1956</u> , that I last saw the deceased alive on <u>November 7, 1956</u> , and that death occurred at <u>9:00 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>al' Dick</u>		M.D.		ADDRESS (Street, city, town, state) <u>Chestertown, Md.</u>		DATE SIGNED <u>11-8-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 10/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fairlee Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Nov. 13-1956 Clara S. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, M</u>	

# CERTIFICATE OF DEATH

BUREAU V. 2

NOV 13 1956

RECEIVED



## 11452 CERTIFICATE OF DEATH

11430

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Strong Nursing Home</b>				d. STREET ADDRESS <b>Kent Circle</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George K. Cannan</b>				4. DATE OF DEATH <b>11/12/56</b> Month Day Year			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1874</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Road Builder owner Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George K. Cannan</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane Caulder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT <b>Mrs. Avis Wheatley Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized circulatory collapse</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis chronic</b> DUE TO (c) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>3 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>53</b> to <b>Nov. 12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 10</b> , 19 <b>56</b> , and that death occurred at <b>6</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>11-12-56</b>							
ACTUAL SIGNATURE <b>A.C. Dick</b> M.D.							
PHYSICIAN'S NAME (Type) <b>A.C. Dick</b> <b>Chestertown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Wells</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 14, 56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clara L. Barnes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 16 1956

RECEIVED

## .11440 CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Q.A. Hospital</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Randolph</b> Last <b>Christian</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22-1903</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min <b>53</b>	11. IF UNDER 24 HRS Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min <b>53</b>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Christian</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>224-14-2278</b>	
17. INFORMANT <b>Mrs. Bessie Christian--</b>		Address <b>Rock Hall, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular disease</b> (c) <b>3 years +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 23, 1953</b> to <b>Oct. 27, 1956</b> , that I last saw the deceased alive on <b>Oct. 27, 1956</b> , and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b> DATE SIGNED <b>11/13/56</b>	
PHYSICIAN'S NAME (Type) <b>WILLARD F. SMITH, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Nov. 15</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar B. Kane</b>		ADDRESS <b>Church Hill, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 11/15/56</b>		24b. REGISTRAR'S SIGNATURE <b>S. Wood Bmg. 22</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 11441 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Chest</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>...</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chestertown, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>Elizabeth</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>...</u>	6. COLOR OR RACE <u>...</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>...</u>
9. AGE (In years lost birthday) yrs. <u>...</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>...</u> Days <u>...</u> Hours <u>...</u> Min. <u>...</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>...</u>	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert L. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Tollie Conn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>...</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>...</u> DUE TO <u>...</u> (c) <u>...</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>...</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>...</u> o. m. <u>...</u> p. m. <u>...</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 23, 1956</u> to <u>Nov. 28, 1956</u> , that I last saw the deceased alive on <u>Nov. 28, 1956</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>...</u> DATE SIGNED <u>...</u>			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		DATE SIGNED <u>...</u>	
PHYSICIAN'S NAME (Type) <u>...</u>		DATE SIGNED <u>...</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>...</u>	<u>...</u>	<u>...</u>	<u>...</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>		24a. REC'D BY REGISTRAR <u>...</u>	
ADDRESS <u>...</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG207 17-12-56

## CERTIFICATE OF DEATH

11433

Reg. Dist. No. 202

11442

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent &amp; Queen Anne's</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>MARIE</u> Last <u>FUCHS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1902</u>	9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August J. Godwin</u>				14. MOTHER'S MAIDEN NAME <u>Shreder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Wm H Fuchs (son)</u>		Address <u>Millington, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease with congestive failure</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus (Possible Kimmelstiel-Wilson Syndrome)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-15</u> , 1956, to <u>11-15</u> , 1956, that I last saw the deceased alive on <u>11-15</u> , 1956, and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.				ADDRESS (Street, city or town, state) <u>Chestertown, Md</u> DATE SIGNED <u>11/15/56</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 17 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crompton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward G. Blair</u> ADDRESS <u>Millington Md</u>				24a. REC'D BY REGISTRAR <u>Clara Barnes</u> DATE <u>11-21-56</u>		24b. REGISTRAR'S SIGNATURE	

W. A. 0558

1956

JOHN W. 0558

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11453 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11434

Reg. Dist. No. 202

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Kent</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">rural Chestertown</span> <span style="float: right;">c. LENGTH OF STAY IN lb <span style="font-size: 1.2em;">i</span></span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.2em;">Kent</span></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">rural Chestertown</span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Thomas</span> <span style="float: right;">First</span> <span style="float: right;">Middle</span> <span style="float: right;">Last</span> <span style="font-size: 1.2em;">Homley</span> <b>4. DATE OF DEATH</b> <span style="font-size: 1.2em;">November</span> <span style="float: right;">Month</span> <span style="float: right;">Day</span> <span style="float: right;">Year</span> <span style="font-size: 1.2em;">8</span> <span style="float: right;">19</span> <span style="font-size: 1.2em;">56</span>				<b>5. SEX</b> <span style="font-size: 1.2em;">male</span> <b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">colored</span> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">July 2, 1890</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">66</span> yrs. <b>IF UNDER 1 YEAR</b> <span style="font-size: 1.2em;">Months</span> <span style="font-size: 1.2em;">Days</span> <b>IF UNDER 24 HRS.</b> <span style="font-size: 1.2em;">Hours</span> <span style="font-size: 1.2em;">Min.</span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">farm laborer</span> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Kent County, Md.</span> <b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U. S. A.</span>				<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">James Homley</span> <b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Harriett Broadway</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <span style="font-size: 1.2em;">yes</span> <span style="float: right;">(If yes, give war or dates of service) <span style="font-size: 1.2em;">WW I</span></span> <b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">214-16-4054</span> <b>17. INFORMANT</b> <span style="font-size: 1.2em;">Ida Homley</span> <span style="float: right;">Address <span style="font-size: 1.2em;">R.F.D. 3, Chestertown, Md.</span></span>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Probable coronary thrombosis or</span> <b>DUE TO</b> <span style="font-size: 1.2em;">Cardiac Arrest</span> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <span style="font-size: 1.2em;">(b)</span> <b>DUE TO</b> <span style="font-size: 1.2em;">(c)</span> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">fell over dead while picking chickens</span> <b>20c. TIME OF INJURY</b> <span style="font-size: 1.2em;">19</span> <span style="float: right;">Month, Day, Year</span> <b>20d. INJURY OCCURRED</b> <span style="font-size: 1.2em;">While at work</span> <span style="float: right;">Not while at work <input type="checkbox"/></span> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <span style="font-size: 1.2em;">(County)</span> <span style="float: right;">(State)</span>				<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> <span style="font-size: 1.2em;">Natural causes <input checked="" type="checkbox"/></span> , <span style="font-size: 1.2em;">Accident <input type="checkbox"/></span> , <span style="font-size: 1.2em;">Suicide <input type="checkbox"/></span> , <span style="font-size: 1.2em;">Homicide <input type="checkbox"/></span> , <span style="font-size: 1.2em;">Undetermined cause <input type="checkbox"/></span> . <b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">Robert W. Farr</span> <span style="float: right;">M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></span> <b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">Robert W. Farr, M. D.</span> <span style="float: right;">ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></span> <span style="float: right;">DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></span> <span style="float: right;">DATE SIGNED <span style="font-size: 1.2em;">NOV. 9, 1956</span></span>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span> <b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">11/10/56</span> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Pozona Cem.</span> <b>22d. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">near - Chestertown, Md.</span> <span style="float: right;">(State)</span>				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">J. Wells Wells</span> <span style="float: right;">ADDRESS <span style="font-size: 1.2em;">State St. 1,</span></span> <b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">Nov. 10-56</span> <b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Clara S. Barnes</span>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 10 1933

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1143501  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>KENT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON (Rural)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - WORTON</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Rosie</u> Middle <u>HYNSON</u> Last <u>NOV</u> <b>4. DATE OF DEATH</b> Month <u>NOV</u> Day <u>9</u> Year <u>1956</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Unknown</u> <b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u> <b>13. FATHER'S NAME</b> <u>Unknown</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Rosie Jones</u> Address <u>615 McDonough St. Bklyn. N. Y.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown, but probably from</u> <u>7953</u> DUE TO <u>natural causes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead under house when she lived alone - Last seen date 11-7-56</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Robert W. Farr</u> <b>EXAMINER'S NAME (Type)</b> <u>ROBERT W. FARR</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>11/9/56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11-13-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Georges Cemetery</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Victor N. Kennedy</u> ADDRESS <u>Still Pond, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>  </u> <b>DATE</b> <u>11/11/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 and 6 may be retained for your files.  
 TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. A.

1911

U. S. A.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 7/11/56 et

## CERTIFICATE OF DEATH

11436

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent St.</u>		d. STREET ADDRESS <u>Kent St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Johnson</u>		4. DATE OF DEATH Month Day Year <u>Nov. 12, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1907</u>
9. AGE (In years last birthday) yrs. <u>49</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Case Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Lousia Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>40-01-7075</u>	
17. INFORMANT <u>Bernie Johnson</u>		Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Hypertension</u> DUE TO Hypertensive Cardiovascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Many years</u> (c) <u>Many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 12, 1956</u> to <u>Nov. 12, 1956</u> that I last saw the deceased alive on <u>Nov. 12, 1956</u> and that death occurred at <u>6:00 P.</u> from the causes and on the date stated above. before <u>11/13/56</u> ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert W. Carr</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert W. Carr</u> <u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>		24a. REC'D BY REGISTRAR <u>Nov. 14-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 16 1956

BUREAU Y. S.

RECEIVED

## 11444 CERTIFICATE OF DEATH

Reg. Dist. No. 11435 02

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mont. &amp; Queen Anne Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William J.</u> Middle <u>Miller</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1880</u>
9. AGE (in years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>06</u> Days <u>00</u> Hours <u>00</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustine Miller</u>		14. MOTHER'S MAIDEN NAME <u>Maude L. Wooley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mr. Wm. J. Miller</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 24</u> <u>56</u> to <u>Nov. 11</u> <u>56</u> , that I last saw the deceased alive on <u>Nov. 11</u> <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>11/12/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u> <u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	24a. REC'D BY REGISTRAR <u>Nov. 14-56</u> 24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11445

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11438

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Mont</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert St.</u>		d. STREET ADDRESS <u>Calvert St.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>V.</u> Day <u>26</u> Year <u>1956</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1900</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mont. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Murray</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-6700</u>	
17. INFORMANT <u>Deceased</u>		Address <u>Calvert St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Burns and probable carbon monoxide poisoning</u> IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>poisoning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deceased was found dead in a burning building in which he had been living.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased was found dead in a burning building in which he had been living.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:00 a.m. Nov. 26, 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Chestertown Mont Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Robert M. Farr</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Robert M. Farr</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Nov. 26, 1956	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calvert St.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown Mont Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>		ADDRESS <u>Baltimore, Md.</u>	24a. REC'D BY REGISTRAR <u>Nov. 27-56</u>
			24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 29 1956

BUREAU V. S.

11446 CERTIFICATE OF DEATH

11439

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Mont</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery &amp; Anne Arundel Hosp.</u>		d. STREET ADDRESS (Coleman's Corner)	
3. NAME OF DECEASED (Type or print) <u>Thomas J. Solon</u>		4. DATE OF DEATH <u>Nov 8, 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Mont Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Letcher Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Rulah Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>184-07-5238</u>	
17. INFORMANT <u>Hospital Rec</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral lacunar accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 12, 1956</u> , to <u>Nov 8, 1956</u> , that I last saw the deceased alive on <u>Nov 8, 1956</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Solon</u> M.D. <u>Chestertown</u>		DATE SIGNED <u>11/8/56</u>	
PHYSICIAN'S NAME (Type) <u>Thomas J. Solon Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11/11/56</u>	<u>Coleman's Cor.</u>	<u>Coleman's Corner, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wells Wells</u> ADDRESS <u>Chestertown</u>		24a. REC'D BY REGISTRAR <u>Nov 10-56</u>	24b. REGISTRAR'S SIGNATURE <u>Clara E. Barnes</u>

RECEIVED

1955

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11447 CERTIFICATE OF DEATH

Reg. Dist. No. 11447 202

1 PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLINGTON</b>			
c. LENGTH OF STAY IN 1b <b>1 day</b>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT + QUEEN ANNE'S HOSP</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>MATTIE</b> Middle <b>ISABELLE</b> Last <b>ROCHESTER</b>				4 DATE OF DEATH Month <b>Nov</b> Day <b>9</b> Year <b>1956</b>			
5 SEX <b>F</b>		6 COLOR OR RACE <b>COL</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 22, 1919</b>	
9 AGE (In years last birthday) <b>37</b> yrs		IF UNDER 1 YEAR: Months <b>9</b> Days <b>9</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William H. Elliott</b>				14. MOTHER'S MAIDEN NAME <b>Mary V. Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-228033</b>		17. INFORMANT <b>Hers. Chas. T.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>POST-OPERATIVE RESPIRATORY DEPRESSION</b> DUE TO <b>ANESTHESIA FOR CHOLECYSTECTOMY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CHRONIC CHOLECYSTITIS + CHOLELITHIASIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>NOV 8, 1956</b> , to <b>NOV 9, 1956</b> , that I last saw the deceased alive on <b>NOV 9, 1956</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESTERTOWN, Md</b> DATE SIGNED <b>11-9-56</b> ACTUAL SIGNATURE <b>Willis Wells</b> M.D. <b>A. T. KEEFE, JR. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 13, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rich Neck Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>F. Church Hill Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willis Wells</b> ADDRESS <b>Chest ertown, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov. 13-56</b>		24b. REGISTRAR'S SIGNATURE <b>Charles B. Barnes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PAU A. 2

955

DEALER

## 11448 CERTIFICATE OF DEATH

Reg. No. 11441021

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>		d. STREET ADDRESS <u>"</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent &amp; Queen Anne Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>RUTH</u> Last <u>ROSS</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1956</u>	9. AGE (In years last birthday) <u>0</u> yrs	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>15</u>		IF UNDER 24 HRS Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES FRANKLIN ROSS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE ELIZABETH COLEMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HOSPITAL RECORDS (Mother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>congenital</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>abnormality of upper respiratory tract</u> DUE TO <u>aspiration</u> (c) <u>aspiration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congenital heart lesion, spina bifida occulta</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 2, 1956</u> , to <u>Nov. 3, 1956</u> , that I last saw the deceased alive on <u>Nov. 3, 1956</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Worton, Maryland</u> DATE SIGNED <u>Florence Deringer Joyce</u>							
ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D.				PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u> <u>Worton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesler Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chesler, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams - Chesler, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov. 6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 7 1956

RECEIVED

## 11449 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>			
c. LENGTH OF STAY IN b. <b>35 yrs</b>				d. STREET ADDRESS <b>...</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent Queen Anne's</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JEWELL</b> Middle <b>KELLOGG</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 5, 1890</b>		9. AGE (In years last birthday) yrs. <b>66</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN JEWELL SMITH</b>				14. MOTHER'S MAIDEN NAME <b>MARY PEASLEE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>LINK</b> <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>HOSPITAL RECORD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>70.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post-operative State: Intestinal Obstruction.</b> DUE TO (c) <b>Intestinal Obstruction.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Concussion.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down stairs.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> p. m. <b>Nov 8 1956</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
				20f. (City or town) (County) (State) <b>Chestertown Kent Md</b>			
21. I certify that I attended the deceased from <b>Nov 8</b> , 19 <b>56</b> , to <b>Nov 11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 11</b> , 19 <b>56</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Chestertown, Md</b>				DATE SIGNED <b>11.11.56</b>			
ACTUAL SIGNATURE <b>A.T. KEEFE, JR. M.D.</b>							
PHYSICIAN'S NAME (Type) <b>A.T. KEEFE, JR. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>V. I.</b>		22b. DATE THEREOF <b>Nov 11, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Mr. Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Wells</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 14. 56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>			

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TOTAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 16 1956

BUREAU V. S.

1

11455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G207 12-3-56 et

11443

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Galts</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Galts -</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Clara</u> Last <u>Sommers</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 14, 1913</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Quillen</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Willbert Sommers</u> Address <u>Galts, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor (postoperative)</u> 297X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Operated in Delaware Jail Hosp. Willing for Md in Aug - 1956 for 6 wks. Hospitalized 6 wks. Home about 4 wks. Found dead in bed about 6 am. To day</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 20 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Millington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Millington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Yellow Millington Md.</u>				24b. REC'D BY REGISTRAR <u>NOV 26 1956</u>		24c. REGISTRAR'S SIGNATURE <u>Hy. Mulford</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on duty is necessary, please etc. the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 26 1956  
BUREAU V. B.



## 11450 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 days</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent &amp; Green Anns</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLIFTON</u> First <u>E</u> Middle <u>WESLEY</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucas</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25, 1913</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cystic Shucker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wesley</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Wesley - Rock Hall</u>		Address <u>Rock Hall records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Meningitis</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/31</u> , 19 <u>56</u> , to <u>11/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/1/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		ADDRESS (Street, city or town, state) <u>Chestertown, Md</u> DATE SIGNED <u>11/1/56</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 5-56</u>	24b. REGISTRAR'S SIGNATURE <u>Class S. Barnes</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint, illegible handwriting.

BUREAU V. 31

NOV 7 1956

RECEIVED